Opening Remarks

Nicole Alexander-Scott, MD, MPH
Director, Rhode Island Department of Health
Thank you to all of our partners here today.
Outline of Today’s Objectives

Where We Are Today
- Why are we here and how did we get here?
- How does the Coalition support state-wide collaboration

Understanding Financial Impact and Preventing Litigation
- Financial impact and underlying resource needs
- Preventing litigation and promoting patient safety

Reporting and Quality Metrics Across the Continuum of Care
- Public information and quality metrics
- Impact and opportunities across the care continuum

Achieving Financial Security through Compliance and Partner Engagement
- Compliance with state and federal guidance
- Engaging partners to support facility and health system initiatives
Where We Are Today

Why are we here and how did we get here?
How does the Coalition support state-wide collaboration
Why are we here and how did we get here?

Healthcare-Acquired Infections (HAIs) and Antimicrobial Resistance (AR):

- Impact patient safety and population health.
- Are increasingly being tied to reimbursement and regulations.
- Can put your facility at risk for litigation.

HAIs and AR cost lives and money!
Why are we here and how did we get here?

FY16 HAC Scores/Penalties Made Publicly Available December 2015

- Met with Senator Whitehouse to review actions being taken in RI March 2016
- Worked with providers/stakeholders to identify next steps for RI March – June 2016

- Began Planning for new Coalition to reinforce resources July – August 2016
- Host kick off meeting for new Coalition to set the stage August 25, 2016

- Host education and best practice workgroup meeting December 7, 2016
- FY17 HAC Scores/Penalties Made Publicly Available December 2016
- Host leadership and policy committee meeting May 8, 2017

7 of 11 acute-care hospitals received penalties based on 2012-2014 data

4 of 11 acute-care hospitals received penalties based on 2013-2015 data
Why are we here and how did we get here?

RIDOH and other stakeholders can reduce HAIs and AR by:

- Providing technical assistance.
- Identifying statewide best practices and priority areas.
- Supporting collaborative efforts and partnerships throughout the state and region.
How does the Coalition support state-wide collaboration?

Healthcare Landscape in Rhode Island
How does the Coalition support state-wide collaboration?

Sharing:
- Patients
- Providers
- Visitors
- Community resources
- Infectious organisms
- Drug-resistant organisms

Responsibility

- As a small state, we are all impacted by the successes and challenges of our partners.
- Working collaboratively to manage patients and resources will lead to healthier Rhode Islanders and better health outcomes across our healthcare facilities and systems.

Healthcare Landscape in Rhode Island
How does the Coalition support state-wide collaboration?

One year ago, HAI prevention and antimicrobial stewardship efforts in Rhode Island looked like this:
How does the Coalition support state-wide collaboration?

Now, HAI prevention and antimicrobial stewardship efforts in Rhode Island are starting to look more like this:

**Increased coordination, collaboration and communication and less duplication of efforts**

<table>
<thead>
<tr>
<th>Rhode Island Department of Health</th>
<th>Healthcentric Advisors/QIN-QIO</th>
<th>HEN/HIIN</th>
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<tbody>
<tr>
<td>Hospital Association of Rhode Island</td>
<td>ICPSNE</td>
<td>HAI Subcommittee</td>
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<tr>
<td>Trade and Professional Organizations</td>
<td>Engaging Partners</td>
<td>AMSEC Taskforce</td>
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**Identify New Partners and Opportunities**

**RI HAI Prevention and Antimicrobial Stewardship Coalition**

<table>
<thead>
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<th>Nursing Homes</th>
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<tr>
<td>Hospitals</td>
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<tr>
<td>Home and Community-based Services</td>
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<td>Expanding Provider Reach</td>
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**Supports existing and new relationships within a more cohesive environment**

**Resource hub to identify and share best practices**
How does the Coalition support state-wide collaboration?

TWO TRACKS FOCUSED ON A SINGLE GOAL: Protecting the health of Rhode Islanders and the sustainability of our healthcare system.

RI HAI Prevention and Antimicrobial Stewardship Coalition

Leadership and Policy Committee

- Work with executive and state leadership to ensure facility policies and resource allocation adequately support HAI prevention and antimicrobial stewardship.
- Develop and support state and national policies that align with coalition goals.

Education and Best Practice Workgroup

- Work with HAI prevention/antimicrobial stewardship leads, champions and subject matter experts to identify gaps in state or facility programs and develop best practices.
- Provide expert information to Leadership and Policy Committee.

- Meetings will be held for each track every 6 months to advance Coalition aims.
- Existing meetings and groups will be leveraged to reduce duplication and support coordination.
How does the Coalition support state-wide collaboration?

Kick-off Meeting – August 25, 2016
- Highlighted best practices and areas of opportunity.
- Demonstrated cross-setting commitment to improve infection prevention practices and expand antimicrobial stewardship programs.

Education and Best Practice Workgroup Meeting – December 7, 2016
- Provided opportunity for open discussion about barriers and resource needs.
- Facilitated cross-setting exchange of ideas and best practices.

Other Events and Successes
- Launched a web-based resource hub for cross-setting infection prevention and antimicrobial stewardship resources [http://healthcentricadvisors.org/ri-hai-pasc/](http://healthcentricadvisors.org/ri-hai-pasc/).
How does the Coalition support state-wide collaboration?

Since we met in August, 2016:

- Hospital Value-Based Purchasing (VBP) Safety Domain and Healthcare-Acquired Condition (HAC) Reduction Program **EXPANDED** to include C. Difficile and MRSA.
- Long-term Care requirements from CMS reformed to include **NEW** requirements related to infection prevention and antimicrobial stewardship.
- CMS adopts **NEW** readmission measures for long-term care facilities expands accountability post-discharge.
- CDC releases **NEW** Core Elements of Outpatient Antimicrobial Stewardship.
Understanding Financial Impact and Preventing Litigation

Financial impact and underlying resource needs
Preventing litigation and promoting patient safety
Impact of Healthcare-Associated Infections & Antimicrobial Resistance

Healthcare-Acquired Infections (HAIs) and Antimicrobial Resistance (AR):

- Impact patient safety and population health.
- Are increasingly being tied to reimbursement and regulations.
- Can put your facility at risk for litigation.

HAIs and AR cost lives and money!
Competency-Based Education

**What it is:** Skill-specific training that requires participants to demonstrate their mastery or understanding of the element they have been trained on – e.g., personal protective equipment (PPE) training followed by a return demonstration of appropriate donning and doffing of PPE.

**Why it is important:** Staff are trained on correct technique, but without a return demonstration of competency, leadership cannot be certain correct technique will be used.

**Identified resource need:** Infection control and education staff do not have the person time and material resources they need to provide this level of training for their staff.
Audit and Feedback for Infection Control Procedures

What it is: Facilities should audit adherence to infection control policies and procedures. These audits should be documented and feedback should be regularly provided to staff.

Why it is important: Deviations from these policies and procedures can have a direct impact on patient safety and need to be corrected.

Identified resource need: Infection control staff does not have the person time they need to audit all policies and procedures to ensure adherence.
Alignment of Infection Control and Antimicrobial Stewardship

**What it is:** Maintaining consistent lines of communication, developing a fair breakdown of responsibilities and defining a clear reporting structure.

**Why it is important:** Infection control and antimicrobial stewardship are both key components of reducing HAIs and AR, but require collaboration between multiple departments and disciplines.

**Identified resource need:** Dedicated person time for all involved to develop coordinated approach and leadership support for culture change.

**Some facilities also need increased access to experts (e.g., infectious disease physicians and pharmacists).**
Reporting and Quality Metrics Across the Continuum of Care

Public information and quality metrics

Impact and opportunities across the care continuum
What is the National Healthcare Safety Network (NHSN)?

- Internet-based system supported by the CDC.
- Healthcare facilities report infection data into the NHSN system.
- NHSN helps healthcare facilities with surveillance, benchmarking and internal quality improvement.

To find out more, visit [http://www.cdc.gov/nhsn/](http://www.cdc.gov/nhsn/) or contact Maureen Marsella at mmarsella@healthcentricadvisors.org (hospitals) or Janet Robinson at jrobinson@healthcentricadvisors.org (long-term care)
How is data from NHSN used in hospitals?

- All acute-care hospitals in RI are submitting data
  - Data is used for Healthcare-acquired condition (HAC) Reduction Program and Hospital Value-based Purchasing (VBP) Program.
  - HAC and VBP result in either positive or negative payment adjustment to hospital’s Medicare reimbursement.
  - HAC based on comparison to other hospitals in the country (“Achievement”).
  - VBP based on achievement and internal improvement (“Improvement”).

To find out more, visit [http://www.cdc.gov/nhsn/](http://www.cdc.gov/nhsn/) or contact Maureen Marsella at mmarsella@healthcentricadvisors.org
How is data from NHSN used in long-term care facilities?

- 17 long-term care facilities in RI are submitting data.
  - Facilities are receiving technical assistance from QIN-QIO.
  - Data not currently linked to Medicare reimbursement.
  - Use of NHSN in long-term care is a clear priority area at both CMS and CDC.
- Data from early adopters (those who use prior to it being mandated by CMS) will likely be used to develop a baseline for future programs.

To find out more, visit [http://www.cdc.gov/nhsn/](http://www.cdc.gov/nhsn/) or contact Janet Robinson at jrobinson@healthcentricadvisors.org
Other facility types submitting data to NHSN

- End-state renal disease facilities
- Long-term care hospitals
- Inpatient rehabilitation hospitals
- Ambulatory surgical centers
- Inpatient psychiatric facilities

*Mandates for data submission and links to reimbursement and/or incentive programs vary by facility type.*
What about antimicrobial stewardship?

Process measures:
- Implementation and adherence to core elements.
- Antimicrobial prescribing data (e.g., pharmacy data, payor data, internal facility tracking, NHSN Antimicrobial Use (AU) module for hospitals).

Outcome measures:
- NHSN Antimicrobial Resistance module for hospitals.
- Incidence of antimicrobial-related adverse drug events
- Changes to facility antibiogram.
- Reduction in certain infections (though it is difficult to definitively name antimicrobial use as proximate cause).
Cross-setting Relationships

**Consider:** Meeting new HAI prevention and antimicrobial stewardship (AMS) requirements may require knowledge and expertise that some facilities don’t have.

**Do:** Provide opportunities for your staff to build relationships across settings that foster shared learning and communication.

**First step:** Identify partners (e.g. facilities, providers) that you commonly share patients with.

**Next step:** Allocate time for your staff to build relationships.

**Impact:** Partners with strong HAI prevention and AMS programs are better able to care for your shared patients and are more financially stable.
Mutually Beneficial Initiatives

**Consider:** HAI rates and AR impact patient outcomes, costs and reimbursement across the continuum of care.

**Do:** Partner with other facilities/providers on initiatives that are mutually beneficial.

**First step:** Work with partners across the continuum to identify shared priorities (e.g. AMS activities that you are both required to implement).

**Next step:** Align activities and messaging, share resources and create accountability.

**Impact:** Ensures that prevention and stewardship efforts are maintained across the continuum of care.
Cross-setting Accountability

**Consider:** When you agree to formal partnerships with other facilities/providers (e.g. preferred partner agreements), you are agreeing to share responsibility for patients – for better or for worse.

**Do:** Consider HAI and AR prevention efforts when forming partnerships.

**First step:** Identify what the key HAI and AR prevention activities are in the healthcare setting in which you are seeking partners.

**Next step:** Include process or outcome measures related to those activities in your agreements.

**Impact:** Assurance that your patients receive a certain standard of care from your partners.
Achieving Financial Security through Compliance and Partner Engagement

Compliance with state and federal guidance
Engaging partners to support facility and health system initiatives
Planning for the Future

Consider: CMS often introduces new, voluntary opportunities to address priority areas into the environment prior to making them mandatory, e.g. National Healthcare Safety Network (NHSN) Patient Safety Module for hospitals.

Do: Pay attention to national or regional initiatives funded by CMS and other agencies (e.g. CDC) and consider the benefits of being an early adopter.

First step: Look for opportunities (e.g. new guidance or tools) that are strongly encouraged by CMS or other agencies.

Next step: Build participation in these opportunities into your workflow (e.g. adopt the NHSN Antimicrobial Use and Resistance module).

Impact: Be better prepared if/when these opportunities become requirements that are linked to reimbursement.
The CDC’s Core Elements of Antimicrobial Stewardship - What are they?

- Developed by the CDC to direct antimicrobial stewardship programs.
- Goal is to reduce unnecessary and/or inappropriate antimicrobial use.
- CDC has released elements for:
  - Acute-care hospitals
  - Long-term care facilities
  - Outpatient providers
Hospitals and Long-Term Care Facilities

Asked to sign statement of leadership commitment that:

- Facility will embrace and execute the core elements for their healthcare setting.
- Identify and convene facility antimicrobial stewardship champions.
  - Signed by all acute-care hospitals, Butler Hospital, Providence VA Medical Center and 36 long-term care facilities
- Full list: [http://www.health.ri.gov/healthcare/about/antimicrobial stewardship/honorroll/](http://www.health.ri.gov/healthcare/about/antimicrobial stewardship/honorroll/)
Outpatient Providers

- Quality Innovation Network-Quality Improvement Organization (QIN-QIO) recruiting 12 outpatient providers (e.g., urgent care, emergency departments, physician offices).
- QIN-QIO will assist outpatient providers in implementing the core elements of antimicrobial stewardship.
- Outpatient providers asked to commit to implementing the core elements.

Contact Maureen Marsella Mmarsella@healthcentricadvisors.org for more information
Patients and Families as Partners

**Consider:** Patient and family adherence to treatment guidance and recommendations can impact the outcomes of the care you provide.

**Do:** See patients and families as partners and their care who have an important perspective to share.

**First step:** Acknowledge patients and families as partners in their care and make sure they have meaningful opportunities to share their perspective.

**Next step:** Develop a patient and family advisory council and ensure that their contributions are given due consideration.

**Impact:** A patient-centered care model that works with patients and families to improve patient outcomes.
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Nicole Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health
Nicole.AlexanderScott@health.ri.gov
Rhode Island HAI Prevention and Antimicrobial Stewardship Coalition – Leadership and Policy Committee

Financial Impact and Underlying Resource Needs
Objective:
Discuss the direct and indirect financial impact of healthcare-associated infections (HAIs) and antimicrobial resistance (AR)

Speakers:
Justine Hastings, PhD
Leonard Mermel, DO, ScM, FSHEA, FIDSA, FACP
Janet Robinson, RN, MEd, CIC
Rhode Island’s Economic health

Justine Hastings, PhD
Rhode Island Innovative Policy Lab @ Brown

Foundation-funded collaboration with the Governor of Rhode Island to use economics and ideal data to improve equity of opportunity in society

Centered on ideal data
- Administrative linked database across agencies; secure and anonymized; 360 view of social program impact and need.
- Additional private sector data partnerships to increase insights
- Interdisciplinary: Economics, Psychology & Economics, Data Science, Computer Science, Public Policy

Define Goal(s) → Understand the challenge(s) → Assess current approaches (causal impact) → Design Improvements (fieldwork + science) → Test Improvements (RCT + scale)
Closing the Achievement Gap
by increasing equity of opportunity so that all children have the ability to reach their potential.

Developing Smart Social Programs
with higher impact per dollar so that we can fight poverty effectively.

Designing Regulation that Works
for business and the environment by designing transparent environmental regulations which are green and grow the economy.

Restoring Community
through improved criminal justice programs, recognizing that society gains when all people are productively engaged.
Challenge: A Shrinking State
Population Change by Age, 2010-2015

Children: 0-17 (Rhode Island: 5.8% decline)

Source: UNC Carolina Population Center
Challenge: A Shrinking State
Population Change by Age, 2010-2015

Prime Working Age: 25-54 (Rhode Island: 2.5% decline)

Source: UNC Carolina Population Center
Challenge: A Shrinking State Population Change by Age, 2010-2015

Elderly: 65+ (Rhode Island: 11.8% growth)

Source: UNC Carolina Population Center
Implications of Population Decline

- Pension obligations are fixed

- Incoming revenues decline as tax base decreases and elderly population grows
  - Infrastructure suffers as economies of scale decline

- Economic growth and population trends are positively correlated...

Source: Bloomberg
Implications of Population Decline

Fiscal condition and population growth are negatively correlated

- States here are ranked from 1 to 50 in terms of short- and long-term debt, as well as unfunded pensions and healthcare benefits

Source: George Mason University Mercatus Center and US Census Data
Clear focus on building jobs

What makes a state attractive for working families?

• Quality of life
  • Healthcare
  • Public infrastructure
  • Schools
  • Environmental factors (weather)

• Economic opportunity
  • Jobs
  • Employment benefits
  • Affordability

Which of these factors are we able to control?
Healthy Rhode Island; Healthy Economy

- Both consumers and employers are influenced by healthcare landscape when making location decisions.
  - Quality of life affects firm location decisions (Love 1999; Boyle 1988; Carn and Rabianski 1991).
  - A 2011 HealthGrades survey found that 83% of consumers are very or somewhat concerned about hospital quality in their community, and that almost 94% reported being willing to go out of their way to seek care at a more highly-rated hospital.

- Creating a healthcare system that is attractive to both employers and skilled workers is key to long-term investment in Rhode Island’s future.
  - Rising healthcare spending is a driver of local and sectoral prosperity (US Department of Health & Human Services 2005).

- So how does Rhode Island compare to the rest of the country, and how can we remain competitive with other states?
Average CR Hospital Safety Rating and Mean State Population Growth 2010-2016

- **New England States**
- **Rhode Island**

- **N = 2867 hospitals nationally**
- CFR’s hospital rating based on 2017 Medicare Hospital Compare data on infections, readmissions, complications, patient experience and outcomes, and other adverse events.
- Note: DC and Maryland excluded from series.

Source: Consumer Reports and US Census Data
Moving Forward

- How can hospitals and policymakers work together to make Rhode Island a national leader in hospital safety?
  - Decision for increased hospital safety benefits the hospital
  - However, there are positive externalities
    - All businesses and the state benefit in the long-run from better quality of life

- What concrete steps go into hospital safety?
  - Within the Hospital
    - Pay for performance? What tools do you have to compensate or reward staff for safety?
  - In Rhode Island, what can the Governor do to benefit firms for creating positive externalities, (or equivalently tax them for creating negative externalities)
    - Can there be a prize for beating competitor states (or a tax for underperformance)?
      - Regional competitors (Massachusetts and Connecticut) as well as national (North Carolina, Utah, Colorado)
      - Award/tax break for hitting a hospital safety score of 50; or reaching the average of high-growth competitor states
      - Award/tax break increases with each subsequent milestone filled and major infection rate lowered
Questions?

- justine_hastings@brown.edu
Hospital-Acquired Infections: Dollars and Sense
Leonard Mermel, DO, ScM, FSHEA, FIDSA, FACP
"Man, we are making a MINT off that thing!"
HOSPITAL-ACQUIRED INFECTIONS: DOLLARS AND SENSE

Dr. Leonard Mermel
Professor of Medicine,
Warren Alpert Medical School of Brown University
Medical Director,
Department of Epidemiology & Infection Control,
Rhode Island Hospital
Adjunct Clinical Professor,
University of Rhode Island College of Pharmacy
Potential Conflicts of Interest

- Patent co-holder of a C. difficile detection method
- Research funding: Bard, CareFusion, Astrellas
- Consultant: Bard; Marvao Medical; PuraCath; American Hospital Assn.
HAI Public Reporting & Financial Impact
Estimated Attributable Cost of HAIs
# Attributable Financial Impact of HAI for Adults in Acute Care Hospitals

<table>
<thead>
<tr>
<th>HAI</th>
<th>Annual Attributable Cost</th>
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<tbody>
<tr>
<td>Surgical site Infections</td>
<td>3,297,285,451</td>
</tr>
<tr>
<td>MRSA SSI</td>
<td>990,539,052</td>
</tr>
<tr>
<td>Central line-associated Bloodstream Infections</td>
<td>1,851,384,347</td>
</tr>
<tr>
<td>MRSA CLABSI</td>
<td>389,081,519</td>
</tr>
<tr>
<td>Catheter-associated Urinary tract Infections</td>
<td>27,884,193</td>
</tr>
<tr>
<td>Ventilator-associated Pneumonias</td>
<td>3,094,270,016</td>
</tr>
<tr>
<td>Clostridium difficile infections</td>
<td>1,508,347,070</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9,779,171,077</td>
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Sources: Zimlichman, et al, JAMA 2013
HAIs contribute to:

• Hospital-Associated Condition Reduction Program

• Value-Based Purchasing Program

• Readmission Penalty Program
Hospital-Associated Condition Reduction Program
Hospital-Associated Condition (HAC) Reduction Program (HACRP)

- Affordable Care Act (ACA) requires CMS to reduce Medicare Inpatient Prospective Payment System provisions by 1% for hospitals in lowest quartile of HAC performance (HAC performance formula consists of infectious & non-infectious harms)

- HACRP began FY 2015 with discharges beginning 10/14
Hospital-Associated Condition (HAC) Reduction Program (HACRP)

• HAC reductions applied after value-based purchasing (VBP) and readmission penalties

• CMS reports HACRP outcomes on Hospital Compare website

• FY 2016 HACRP resulted in estimated $364 million reduction in hospital payments
How Are We Doing in RI?
Financial Impact of HACRP for Acute Care Hospitals in Rhode Island

FY 2016
• 7 hospitals ranked in lowest performing quartile; received payment reductions of $3,457,200

FY 2017
• 4 hospitals ranked in lowest performing quartile; received payment reductions of $1,111,400

FY 2018 estimate (HARI)
• 2 hospitals predicted may be ranked in lowest performing quartile; estimated payment reductions of $619,800
Value-Based Purchasing
Financial Impact of Value-Based Purchasing (VBP) Program for Acute Care Hospitals in US

FY 2016 – National data

• 1806 hospitals received positive adjustment
• 1235 hospitals received negative adjustment
How Are We Doing in RI?
Financial Impact of VBP Program for Acute Care Hospitals in Rhode Island

FY 2016
• $104,500 negative adjustment

FY 2017
• $604,200 positive adjustment

FY 2018 estimate (HARI)
• $1,299,200 positive adjustment
Readmission Penalty Program
How Are We Doing in RI?
Readmission Penalty Program for Acute Care Hospitals in Rhode Island

FY 2016
• $1,726,100 negative adjustment

FY 2017
• $1,806,300 negative adjustment

FY 2018 estimate (HARI)
• $1,843,100 negative adjustment
Summary

• In addition to potential litigation, HACRP, VBP, and readmission penalties create paradigm shift for acute care hospitals impacting financial bottom line and public viewing of HAI rates

• HACRP payment reductions in RI acute care hospitals have dropped from $3.5 million in FY 2016 to estimated $0.5 million in FY 2018

• VBP estimated to positive adjustments over $1 million for RI acute care hospitals in FY 2018

• Readmission penalties of nearly $2 million estimated for RI acute care hospitals in FY 2018
Summary

With so much money at stake, hospital infection control and prevention programs in Rhode Island should:

• Be well-resourced with appropriate budget, infection preventionist & hospital epidemiologist FTEs, IT and administrative support

• Work together with QA depts, and ideally human factors engineers, to create and implement strategies to reduce harms to our patients

• Work together with antibiotic stewardship program to reduce harms from HAIs due to C. difficile and MDR organisms
Einstein discovers that time is actually money.
Questions?

Contact Information: LMMermel@Lifespan.org
CMS Reform of Requirements for Long-Term Care Facilities

483.80 Infection Control

Janet Robinson, RN, MEd, CIC
CMS Reform of Requirements for Long-Term Care Facilities
483.80 Infection Control

HAI/AMS Coalition - Leadership and Policy Meeting
Janet D. Robinson MEd RN CIC
May 8, 2017
Current HHS Initiatives

- Reducing unnecessary hospital readmissions
- Reducing the incidences of healthcare acquired infections
- Improving behavioral healthcare
- Safeguarding nursing home residents from the use of unnecessary psychotropic (antipsychotic) medications
LTC infection prevention a national priority

- Changes in the LTC resident population have increased the risk of Healthcare Associated Infections (HAI’s)

- Regulatory requirements and standards of care must be met even though challenges exist which influence the development and implementation of infection prevention practices
483.80 Infection Control

a) Infection Prevention and Control Program

b) Infection Preventionist (IP)

c) IP Participation on Quality Assessment Committee

d) Influenza and Pneumococcal Immunizations

e) Linens

f) Annual Review
3 Implementation Phases

Phase 1 – November 28, 2016
- Infection Control Program (excluding (a)(3))

Phase 2 – November 28, 2017
- Facility Assessment (part of (a)(1))
- Antibiotic Stewardship (a)(3)

Phase 3 – November 28, 2019
- Infection Preventionist (b)(c)
How Will Surveyors Assess?

• **Short term**
  – no change in survey process
  – old interpretative guidelines from CMS

• **Long term**
  – new interpretative guidelines (currently in draft form)
  – 3 year pilot project (in the 2\textsuperscript{nd} year)
    • assessment of infection prevention regulations in LTC, acute care and during transitions of care
    • Pilot surveys – educational, no citations
    • Proposed outcome – new surveyor infection control tools and survey processes (implementation date unknown)
Gap Assessment

Domains

- program & infrastructure
- surveillance & reporting
- respiratory etiquette
- injection safety
- personnel & resident safety
- HH, PPE
- antibiotic stewardship
- environmental cleaning

Identifying and addressing gaps improves infection prevention activities
Facility must designate one or more IP’s who are
- Responsible for the Infection Prevention/Control Program
- Working at least part time at the facility

Infection Preventionist must
- Be qualified by education, training, experience or certification
- Have completed specialized training in infection prevention and control

*Must be implemented by November 28, 2019*
Education Options

• Healthcentric Advisors – 6-Part Series (jumpstart)

• Certification Board of Infection Control
  – Certification (CIC)

• Association of Professionals in Infection Control
  – Certificate

• American Health Care Association
  – Webinar based
  – Certificate
Antimicrobial Stewardship

• 483.80 (a) (3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

  – Core Elements of Antibiotic Stewardship for Nursing Homes
    • https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html
  – Nursing Home Antimicrobial Stewardship Guide
    • https://www.ahrq.gov/nhguide/index.html
Contact Information:
JRobinson@healthcentricadvisors.org
Rhode Island HAI Prevention and Antimicrobial Stewardship Coalition – Leadership and Policy Committee

Preventing Litigation and Promoting Patient Safety
Objective:
Discuss the direct and indirect financial impact of healthcare-associated infections (HAIs) and antimicrobial resistance (AR).

Speakers:
Gerard R. Goulet, Esq.
Margaret Vigorito, MS, RN, PHR, SHRM-CP, CPHQ
Legal Liability for Healthcare-Acquired Infections

Gerard R. Goulet, Esq.
Negligence

Most common legal theory for liability

Four elements to prove:
- Existence of a duty
- Breach of duty
- Injury
- Legal causation
Fifth Element:

- Someone willing to make a claim
Provider Duty

First Element to Prove

Duty Owed to Person Harmed

Scope of Duty---Standard of Care
Duty---Obligation to conform to the standard of care

Judge or jury determine based on expert testimony, common sense, and written standards.

The degree of reasonable care a patient's apparent or known condition requires.
Written Standards

- Licensure Regulations
- Institutional Rules/Policies
- Accreditation Standards
- Reference Books
Breach of Duty

Second Element to Prove

Deviation From Standard
Factors to Consider

**Patient**

- Duration of Patient Stay
- Severity of illness or injury at admission
- Function and capacity of immune system during stay
Organization

- General cleanliness of hospital and treatment setting
- Concentration of Patient beds
- Cleanliness of water systems
- Cleanliness of building surfaces
- Sterility of Medical Devices
**iatrogenic**

- Care with which doctors, hospital staff, nurses etc. perform
- Frequency with which hands are washed
- Use of antibiotics
- Care used during invasive procedures
Injury

Third Element to Prove

Physical, Financial or Emotional Harm

Goal to return individual to status before injury---

Usually by means of compensation, i.e. money
Proximate Cause

*Fourth Element to Prove*

Usually the key element

Breaking the chain of causation: intervening events
Comparative Negligence

Patient collects only a percentage

Amount varies based on patient's degree of negligence
Responsibility

- Individual staff liable for own acts as are independent contractors
- Employers liable for job-related acts of employees or agents - Respondeat Superior
- Institutions also liable for breach of duties owed to patients and others
- Supervisors not employers of their staffs, thus not liable for employees but liable for own negligent actions
Supervisor Liability

- If assigns task that supervisor knows or should know that subordinate can not or should not perform

- Does not supervise employee to the degree known to be needed

- Is present and fails to take action to avoid injury

- Does not properly allocate staff time
Ultimately

Difficult to show how infection transmitted---only that it occurred while in treatment

Hospital most likely to be held responsible

Questions:

- How acquired?
- Why not promptly treated?
- Whether could or should have been prevented.
Patient acquires infection during hospital stay

Patien must prove:

- Contracted infection in hospital
- Hospital breached duty in failing to follow policy or procedure to prevent infection
- Hospital negligence caused infection
- Patient condition worsened because of infection
What to do

- Act in reasonable manner to recognize, report and try to control infection
- Practice Parameters
- Monitor patient outcomes
- Infection surveillance, reviewing and revising infection prevention policies and procedures, providing in-service training, adhering to state and national patient safety goals
- Never ending vigilance
Questions?

Gerard R. Goulet, Esq.
Principal, Health Policy Analytics, LLC
gerard.goulet@gmail.com
The Impact of Safety Culture and How to Achieve It

Margaret Vigorito, MS, RN, PHR, SHRM-CP, CPHQ
The Impact of Safety Culture and How to Achieve It

Margaret Cornell Vigorito, MS, RN, CPHQ

May 8th, 2017
Safety Culture – *What?*

- **Defines:**
  - Team attitudes
  - Norms
  - Behaviors
- Sets tone for “how work gets done around here”
- Impacts overall “team” performance
Safety Culture…
the Road to Improvement
Safety Culture…
oops!
Safety Culture – Why?

Strong Correlation Between ...

Team Perception of Safety Climate

Clinical Outcome Performance
Role of Senior Leadership

- The development of safety culture begins with senior leaders.
- When leaders support the creation and maintenance of a strong patient safety program, patient outcomes improve.
Safety Culture – How?

- Basic QI methods
- Keep it simple!
Applying the PDSA Cycle

Plan
Identify Program

Do
Implement program components

Act
Develop improvement strategies

Study
Monitor results
Plan: Identify a Patient Safety Program

Sample programs:

- CUSP
- Team STEPPS
- High Reliability
Do: Implement Program Components

Sample Components:

- Identify Executive Champion
- Safety program training
- Conduct leadership safety rounds
- Conduct daily safety huddles
- Safety culture assessment and reassessment
Study: Monitor results

- Annual safety culture assessment results
- Trend data over time and correlate with clinical outcome data
- Trend by work area and facility-wide
Act: *How can we do better?*

- Identify improvement opportunities
- Develop improvement strategies
The Rhode Island ICU Collaborative

A STATEWIDE DEMONSTRATION OF THE IMPACT OF PATIENT SAFETY CULTURE
ICU Collaborative – What?

- Statewide ICU patient safety initiative, 2006-2012
- 100% of RI adult ICUs enrolled (23 ICUs from 11 hospitals)
- **Goal:** To improve patient safety and clinical outcomes for adult ICU patients through the development of a unit based safety program and implementation of evidenced-based practices.
ICU Collaborative – Why?

Strong Correlation Between …

Team Perception of Safety Climate

Clinical Outcome Performance
ICU Collaborative – How?

- Comprehensive Unit-Based Safety Program (CUSP) – 2005
- Ventilator Associated Pneumonia Bundle (VAP) – 2006
- Sepsis – 2008
- Palliative Care - 2010
CUSP – Comprehensive Unit Safety Program

1. Safety Culture Assessment
2. Science of Safety Training
3. Staff Identify Safety Hazards
4. Senior Executive Partnership
5. a. Learn from Safety Defects
   b. Tools to Improve
6. Safety Culture Reassessment
Safety Attitudes Questionnaire (SAQ)

- Frontline caregivers assessment of patient safety across 6 domains
- Valid and reliable
- Developed at University of Texas by Bryan Sexton, PhD
- Baseline assessment administered in 2005 and then annually
SAQ Action Plan (SAQAP)

- Documented plan of action identifying:
  - Cultural improvement opportunities
  - Interventions based on SAQ results

The “ACT” cycle of PDSA
ICUs who develop a Safety Attitudes Questionnaire Action Plan (SAQAP) in response to their units’ 2007 SAQ results will demonstrate significantly greater improvement in the 2008 SAQ survey and infection outcomes compared to those that did not have an SAQAP
Aims

- To analyze the impact of the SAQAP on the 2008 SAQ survey results compared to 2007 survey results across six safety domains

- To determine the impact of the SAQAP on 2008 CLA-BSI and VAP rates compared to 2007 CLA-BSI and VAP rates
Methods - Safety Attitudes Questionnaire (SAQ)

- Administered by Pascal Metrics HealthBench™
- 5 point Likert scale (disagree strongly → agree strongly)
- Administered 2007 and 2008 to all 23 ICUs
- Assessment in 6 domains:
  - Teamwork
  - Safety climate
  - Perceptions of management
  - Work conditions
  - Job satisfaction
  - Stress recognition
Methods – BSI and VAP

- Collected and submitted by each hospital via web-based tool (Pre-NHSN)
- NNIS definitions
- 2007 and 2008 annual mean rates reported per 1000 line days and 1000 ventilator days
Methods – Intervention

- SAQAP development strongly recommended
- SAQ improvement toolkit
- Educational learning session/site visits
- Survey to track SAQAP development and completion
Results – Units with Action Plans

- 39% (9/23) units developed SAQAP
  - Median response rate: 83% (range: 80-94%)
  - Higher safety culture scores on 5/6 SAQ domains, compared to units without SAQAP
- 10.2% decrease in BSI rates
- 15.2% decrease in VAP rates
Results – Units **without** Action Plans

- 61% (14/23) units had no plan
  - Median response rate=83% (range=67-100%)
- Higher safety culture scores on 1/6 SAQ domains, compared to units with SAQAP
  - 2.2% decrease in BSI rates
  - 4.8% increase in VAP rates
Results - % change in SAQ Scores 2007 to 2008
Results - % change in BSI and VAP 2007 to 2008
HAI and AMS Initiatives

Strong Correlation Between ...

Team Perception of Safety Climate

HAI Outcome Performance

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References


Resources

Action Planning Tool for the AHRQ Surveys on Patient Safety Culture
http://www.ahrq.gov/sites/default/files/publications/files/planningtool_0.pdf

Agency for Healthcare Research and Quality Patient Safety Network
https://psnet.ahrq.gov/primers/primer/5/safety-culture

Armstrong Institute for Patient Safety and Quality
http://www.hopkinsmedicine.org/armstrong_institute/training_services/cusp_offerings/cusp_guidance.html

Team Check Up Tool

TeamSTEPPS Pocket Guide
Continuing on the Road to Improvement
Rhode Island HAI Prevention and Antimicrobial Stewardship Coalition – Leadership and Policy Committee

Public Information and Quality Metrics
Objective:
Understand current and future HAI and antimicrobial stewardship (AMS) reporting requirements.

Speakers:
Robin Neale, MS, MT(ASCP)SM, CIC
Kerry LaPlante, Pharm D., FCCP
Resetting the Bar: the NHSN Rebaseline

Robin Neale, MS, MT(ASCP)SM, CIC
Resetting the Bar: the NHSN Rebaseline

Rhode Island Healthcare-Acquired Infection Prevention and Antimicrobial Stewardship Coalition Leadership and Policy Committee

May 8th, 2017

Robin Neale MS, MT(ASCP)SM, CIC
Director Infection Prevention and Clinical Effectiveness
Care New England Health System
Objectives

- Describe the NHSN Rebaseline
- Explain how the change may impact
  - Perceived facility performance
  - Public reporting
  - Insurer payment programs
National Healthcare Safety Network (NHSN)

- Nation’s most widely used healthcare-associated infection (HAI) tracking system
- 17,000 medical facilities participate
  - acute, psychiatric, long-term, and rehab hospitals
  - outpatient dialysis centers
  - ambulatory surgery centers
  - nursing homes
- Strict protocols with definitions for reporting infections
- NHSN provides users with data to benchmark performance toward eliminating HAI
- NHSN provides CMS with HAI data for public reporting and payment purposes (VBP, HAC)
Standardized Infection Ratio (SIR)

- Summary measure used for benchmarking HAIs
- Adjusts for **facility** and **patient-level** factors that contribute to **HAI risk** within each facility
Standardized Infection Ratio (SIR)

- The SIR compares the actual number of HAIs observed to what would be predicted:

\[
\text{SIR} = \frac{\text{# Observed Infections}}{\text{# Predicted Infections}}
\]

Your actual infections

Predicted infections at your facility, using the NHSN aggregate data during baseline period and adjusting for risk factors in your population

- SIR >1 means a facility has MORE infections than predicted
- SIR <1 means a facility has fewer infections
So why the Rebaseline?

1. Some of the baselines in use are very old
2. Additional analysis has been done regarding which risk factors have significant impact toward developing infection
3. Protocols and definitions have changed over time
## 1. Rebaseline Updates Aggregate Data Time Periods

<table>
<thead>
<tr>
<th>HAI Type</th>
<th>Original National Baseline Data</th>
<th>2015 Rebaseline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute Care Hospitals (ACH)</td>
<td></td>
</tr>
<tr>
<td>CLABSIs</td>
<td>2006-2008</td>
<td>2015</td>
</tr>
<tr>
<td>CAUTIs</td>
<td>2009</td>
<td>2015</td>
</tr>
<tr>
<td>SSIs</td>
<td>2006-2008</td>
<td>2015 (ACH only)</td>
</tr>
<tr>
<td>Hospital-onset <em>C. difficile</em></td>
<td>2010-2011</td>
<td>2015</td>
</tr>
<tr>
<td>Hospital-onset MRSA bacteremia</td>
<td>2010-2011</td>
<td>2015</td>
</tr>
<tr>
<td>Long-term Acute Care Hospitals (LTACH)</td>
<td>2013</td>
<td></td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facilities (IRF)</td>
<td>2013</td>
<td></td>
</tr>
</tbody>
</table>

[www.cdc.gov/nhsn/2015rebaseline/](www.cdc.gov/nhsn/2015rebaseline/) : CDC NHSN
2. Rebaseline Updates Risk Models

- Risk adjustment is the process used to account for differences in risk that may impact the number of infections (such as - type of facility, unit, bed size, or patient factors such as age or BMI)

- When the data are risk-adjusted
  - makes comparisons more meaningful
  - supports “fairness” when comparing different facilities
## Risk Factors – ACH Rebaseline Model

<table>
<thead>
<tr>
<th>Factor</th>
<th>CLABSI</th>
<th>CLABSI-N</th>
<th>CAUTI</th>
<th>CDI</th>
<th>MRSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location type (med, surg, ICU…)</td>
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<td></td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility Type (Gen, VA, Onc…)</td>
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<td>✅</td>
<td>✅</td>
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<td>Med School Affiliation</td>
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<td>✅</td>
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<tr>
<td>Inpatient CO prevalence rate</td>
<td></td>
<td></td>
<td></td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>CDI Test Type</td>
<td></td>
<td></td>
<td></td>
<td>✅</td>
<td></td>
</tr>
<tr>
<td>Birthweight</td>
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<td></td>
<td></td>
<td></td>
<td>✅</td>
</tr>
<tr>
<td>Length of Stay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅</td>
</tr>
<tr>
<td>Reporting from ED/OBS locations</td>
<td></td>
<td></td>
<td></td>
<td>✅</td>
<td>✅</td>
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<tr>
<td>Facility Bed size</td>
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<td>✅</td>
<td>✅</td>
<td></td>
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<tr>
<td># ICU beds</td>
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<td></td>
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<td></td>
<td>✅</td>
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## Risk Factors – ACH Rebaseline Model - CMS

<table>
<thead>
<tr>
<th>Factor</th>
<th>COLO</th>
<th>HYST</th>
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<tbody>
<tr>
<td>Cancer Hospital</td>
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<td>✓</td>
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<tr>
<td><strong>Patient Level Factors:</strong></td>
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<td></td>
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<tr>
<td>Age</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ASA Score</td>
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<td>✓</td>
</tr>
<tr>
<td>BMI</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Closure technique</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gender</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Excludes infections present at time of surgery (PATOS) and select outliers

NHSN Rebaseline Webinar 1
To Summarize...

1. The 2015 Rebaseline serves as a new “reference point” going forward
2. New risk adjustment methodology has been introduced
3. New starting point for updated protocols, including exclusion criteria
What does the Rebaseline mean for our data?

What can we expect going forward?
SIRs will Shift

*C. difficile* Lab ID Event SIR
CY 2016

SAME HOSPITAL DATA... 2 different baseline years, 2 different Risk Models!
Sometimes the Shift is Dramatic

MRSA Lab ID Event SIR
CY 2016
Another Example

CAUTI ICU SIR
CY 2016

A
B
C
D
E
K

Original Baseline
New 2015 Baseline
Which Baseline should we use?
SIR Comparisons Over Time

Going forward, begin to use the new Rebaseline
- Hospital Compare has already transitioned
- CDC will use for HAI Progress Reports
- Show future improvement

New 2015 Rebaseline

Use the old baseline as needed to:
- Show improvement over time, through 2016
- Review data being used in CMS VBP program through 2016
Example:
Current CLABSI data might look like this!

NHSN Original Baseline 2006-2008

Statistically Better than predicted!
Then you run your SIR under the Rebaseline...
During Transition Years – clearly note Baselines!

CLABSI SIR

2014: 0.43  2015: 0.33  2016: 0.28

2015: 0.54  2016: 0.47

2006 – 2008 Original Baseline

2015 Rebaseline
Always use the same Baseline when comparing data over time!

- Different baseline population!
- Different risk adjustment!
Implications for Public Reporting

- CMS has transitioned to 2015 Rebaseline for public reporting
- It is possible you may see some unexpected performance scores, and the SIR may be higher than initially reported internally at your facility
Implications for CMS VBP Reporting

- FY17 and 18 program years use SIRs calculated under old baselines
- FY19 (performance period is now) will use the 2015 Rebaseline

### CDC’s Standard Population Data in the Hospital VBP Program

<table>
<thead>
<tr>
<th>NHSN Measures Baseline Periods</th>
<th>FY 2017 Program year *</th>
<th>FY 2018 Program year *</th>
<th>FY 2019 Program year **</th>
<th>FY 2020 Program year **</th>
</tr>
</thead>
</table>

* CDC will use “current standard population data” to calculate measure data that we will translate into scores on the measures.

** CDC will use “new standard population data” (CY 2015) to calculate measure data that we will translate into scores on the measures.
Implications for Private Payer P4P

- SIM Measure Alignment Workgroup
  - CAUTI and CDIFF are two of the seven Core Measures
  - CLABSI, MRSA, SSI are on the menu as options

- When negotiating improvement goals, consider
  - which Baseline will be used...
  - whether comparative and performance periods cross Baselines...
Questions?

THE NHSN STANDARDIZED INFECTION RATIO (SIR)

A Guide to the SIR
Updated January 2017. Please see Page 2.

Contact Information:
RNeale@Wihri.org
Antimicrobial Stewardship: 
NHSN AU/AR Module for Hospitals 
Cost Savings and Preparing for the Future

*Kerry LaPlante, Pharm D., FCCP*
~ Antimicrobial Stewardship ~
NHSN AU/AR Module for Hospitals
Cost Savings and Preparing for the Future

Kerry L. LaPlante, Pharm.D., FCCP
Professor of Pharmacy,
University of Rhode Island, College of Pharmacy

Adjunct Professor of Medicine,
The Warren Alpert Medical School of Brown University

Senior Director of the Rhode Island Infectious Diseases Research (RIID) Program
Co-Director of Antimicrobial Stewardship Program, and Infectious Diseases Pharmacotherapy Specialist, Providence Veterans Medical Center, RI
The Life-Saving Benefits of Antibiotic Use

- Once deadly infectious diseases treatable, substantially reducing deaths compared to the pre-antibiotic era

- Important adjunct to modern medical advances
- Surgeries
- Transplants
- Cancer therapies

Currently.....

- No new classes of antibiotics developed
- More toxic antibiotics being used to treat infections
- Antibiotics are a precious and finite resource

Appropriate Antibiotic Use is a National Priority
Antibiotics caused US deaths to decline by ~220 per 100,000 in 15 years.

All other medical technologies reduced deaths by ~20 per 100,000 over the next 45 years.

CDC Core Elements of Antibiotic Stewardship Programs (ASP)

The [critical access] hospital’s antimicrobial stewardship program includes the following core elements:

1. **Leadership Commitment is critical to success of ASPs**
   - Dedicating necessary personnel, financial and information technology resources

2. **Accountability**
   - Appoint single leader responsible for program outcomes
   - Physician involvement demonstrated to be highly effective

3. **Drug Expertise**
   - Appointing a single pharmacist leader responsible for working to improve antibiotic use

4. **Education**
   - Educating healthcare providers about resistance and encouraging optimal prescribing patterns

5. **Action**
   - Implement policies and Interventions to Improve antibiotic use

6. **Tracking**
   - Monitoring the antimicrobial stewardship program, which may include information on antibiotic prescribing and resistance patterns

7. **Reporting**
   - Regularly report findings to healthcare providers and other relevant staff

The Joint Commission recommends that organizations use this CDC document when designing their antimicrobial stewardship program.
Shifting the way we approach improving Antibiotic Use

- We need to learn from the successful model of hospital infection prevention & control
- For decades, preventing infections in hospitals was viewed as the primary responsibility of the infection control program
- Preventing infections is increasingly viewed as the primary responsibility of all healthcare providers
  - Systems approach
  - Surveillance
Interdisciplinary team

Methods: Our ASP team of attending and fellow ID physicians, a clinical ID pharmacist and fellow prospectively audited all inpatient antimicrobial use (IV and PO) daily (Mon – Fri)
What type of Outcomes do we measure?

- CDI Rates (NHSN and your ICP)
- Resistance
- Antibiotic use (NHSN)
- Costs—Overall costs/ PD (Pharmacy and Redbook)
- Process metrics
  - Decline in Urinary Cultures
  - Workload (time spent on pt review and intervention)
  - Acceptance rates of interventions
  - ID consults – ID consults/ 1000 PD
- Adverse Events
- Patient Outcomes
  - LOS, mortality and readmission
National Healthcare Safety Network (NHSN) Antibiotic Use Option (released in 2011)

Objective: Measure antibiotic use to provide risk-adjusted inter- and intra-facility comparisons

- Provide a mechanism for facilities to report and analyze antimicrobial usage as part of antimicrobial stewardship efforts at their facility
- Allow for risk-adjusted comparison of antimicrobial use to a national aggregate
- Voluntary Reporting (need eMAR and BCMA)

Antibiotic resistance surveillance option also available

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td>Vancomycin</td>
<td>120.3</td>
<td>107.7</td>
<td>111</td>
<td>96.5</td>
<td>435.5</td>
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<tr>
<td>2</td>
<td>Piperacillin/Tazobactam</td>
<td>105.7</td>
<td>110.3</td>
<td>104.2</td>
<td>84</td>
<td>404.2</td>
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<td>3</td>
<td>Ceftriaxone</td>
<td>40.9</td>
<td>37.7</td>
<td>51.2</td>
<td>42.7</td>
<td>172.5</td>
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<td>4</td>
<td>Azithromycin</td>
<td>48</td>
<td>40.3</td>
<td>39.8</td>
<td>35.4</td>
<td>163.5</td>
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<td>5</td>
<td>Ciprofloxacin</td>
<td>31.8</td>
<td>26.9</td>
<td>26.8</td>
<td>16.6</td>
<td>102.1</td>
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<td>6</td>
<td>Cefazolin</td>
<td>18.9</td>
<td>25.1</td>
<td>23.2</td>
<td>32.7</td>
<td>99.9</td>
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<td>7</td>
<td>Metronidazole</td>
<td>30.2</td>
<td>26.1</td>
<td>25</td>
<td>13.9</td>
<td>95.2</td>
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<td>8</td>
<td>Amoxicillin/Clavulanate</td>
<td>12.7</td>
<td>17.8</td>
<td>17.2</td>
<td>16.6</td>
<td>64.3</td>
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<tr>
<td>9</td>
<td>Ampicillin/Sulbactam</td>
<td>14.9</td>
<td>13.2</td>
<td>13.5</td>
<td>14.2</td>
<td>55.8</td>
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<td>10</td>
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<td>12.3</td>
<td>10</td>
<td>7.7</td>
<td>13</td>
<td>43</td>
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</table>
NHSN AU Option: Standardized Antimicrobial Administration Ratios (SAAR) Table

<table>
<thead>
<tr>
<th>Year</th>
<th>AU Days</th>
<th>Predicted AU Days</th>
<th>Days Present</th>
<th>SAAR</th>
<th>P value</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All antimicrobials used in adult ICUs and wards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>9793</td>
<td>10806.061</td>
<td>18785</td>
<td>0.906</td>
<td>&lt; 0.001</td>
<td>0.888, 0.924</td>
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<tr>
<td>2016</td>
<td>8837</td>
<td>10893.226</td>
<td>19254</td>
<td>0.811</td>
<td>&lt; 0.001</td>
<td>0.794, 0.828</td>
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<tr>
<td>Antimicrobials used for hospital-onset/multi-drug resistant infections in adult ICUs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2015</td>
<td>556</td>
<td>617.946</td>
<td>2003</td>
<td>0.900</td>
<td>0.012</td>
<td>0.827, 0.977</td>
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<tr>
<td>2016</td>
<td>335</td>
<td>472.331</td>
<td>1531</td>
<td>0.709</td>
<td>&lt; 0.001</td>
<td>0.636, 0.788</td>
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<td>Antimicrobials used for hospital-onset/multi-drug resistant infections in adult wards</td>
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<tr>
<td>2015</td>
<td>2129</td>
<td>1960.710</td>
<td>16782</td>
<td>1.086</td>
<td>&lt; 0.001</td>
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<td>2016</td>
<td>1806</td>
<td>2070.651</td>
<td>17723</td>
<td>0.872</td>
<td>&lt; 0.001</td>
<td>0.833, 0.913</td>
</tr>
</tbody>
</table>

CDC Core Elements: TRACKING and REPORTING!!!
### Outcomes: Pre- vs. Post-ASP

<table>
<thead>
<tr>
<th>Outcome</th>
<th>No. of events/ No. of patients Post-ASP</th>
<th>No. of events/ No. of patients Pre-ASP</th>
<th>HR (95% CI)</th>
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</thead>
<tbody>
<tr>
<td>All-cause 14-Day Mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unadjusted</td>
<td>72/1,375</td>
<td>52/1,321</td>
<td>1.337 (0.936-1.910)</td>
</tr>
<tr>
<td>Adjusted</td>
<td>72/1,375</td>
<td>52/1,321</td>
<td>1.412 (0.915-2.179)</td>
</tr>
<tr>
<td>Matched</td>
<td>31/553</td>
<td>21/553</td>
<td>1.429 (0.818-2.495)</td>
</tr>
<tr>
<td>All-cause Inpatient Mortality</td>
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</tr>
<tr>
<td>Unadjusted</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted</td>
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</tr>
<tr>
<td>Matched</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge</td>
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<tr>
<td>Unadjusted</td>
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<td></td>
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<tr>
<td>Adjusted</td>
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<tr>
<td>Matched</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>30-Day Readmission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unadjusted</td>
<td>448/1,375</td>
<td>361/1,321</td>
<td>1.235 (1.075-1.419)</td>
</tr>
<tr>
<td>Adjusted</td>
<td>448/1,375</td>
<td>361/1,321</td>
<td>1.150 (0.971-1.363)</td>
</tr>
<tr>
<td>Matched</td>
<td>164/553</td>
<td>158/553</td>
<td>1.093 (0.869-1.376)</td>
</tr>
</tbody>
</table>

Our AMS program demonstrated a decreased in:

- Length of Stay
- Broad-spectrum antimicrobial use,
- Antimicrobial costs
- Adverse events
One Year Cost savings:

- ↓$88,407  Pre AMS to the AMS in first 6 months
- Estimated savings in AU only (Average Wholesale Price)  $176,814 first year

Cost not assessed

- Pharmacy time (orders, dispensing, etc)
- Nursing time (hanging meds, etc)
- Prevention of ADEs, med errors
- Cost savings from decrease LOS (~$3,500/day ICU and 2000/day medical ward)
Room and board is largest cost component of inpatient stays


Assumptions on Cost Savings on LOS Decrease

*Cohort all inpatients on antibiotics

<table>
<thead>
<tr>
<th></th>
<th>Q1 25%</th>
<th>Q2 50%</th>
<th>Q3 75%</th>
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</thead>
<tbody>
<tr>
<td>Pre</td>
<td>3 days</td>
<td>5 days</td>
<td>8 days</td>
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<tr>
<td>(n=1321)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post</td>
<td>2 days</td>
<td>4 days</td>
<td>7 days</td>
</tr>
<tr>
<td>(n=1375)</td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

Taking 50% of post group (688 patients) ward decrease in LOS at Med ward cost of $1,974 =

$1,358,000 in one year
**Clostridium difficile** Infections (CDI) per FY

Comparing unique cases on admission to facility with Hospital Onset (HO) Healthcare associated (>= 48hours from admit)
Length of Stay and Cost Per Stay for *Clostridium Difficile* Infection

- Aggregate costs of hospitalizations associated with CDI are an estimated $8.2 billion per year
- CDI is associated with longer hospital length of stay and higher average cost per stay

![Graph showing length of stay and cost per stay](image)

---

*Data is from 2009.
CDI=C. difficile infection.
Submission Metrics

- **132 facilities submitted at least 1 month of data**
  - From 30 states: AZ, CA, CO, CT, FL, IA, ID, IL, IN, KS, KY, MA, MI, MN, MO, NC, ND, NE, NM, NY, OH, OK, OR, RI, SD, TN, TX, UT, VA, WI
  - Bed size:
    - Average = 225
    - Median = 208
    - Min/Max = 11, 919
  - 61% teaching hospitals
    - 56% major teaching
  - 92% facility submission part of health system submission or large academic medical center
  - Using 6 vendors and ‘homegrown’ systems

- **Working with additional groups to continue to grow submission during 2016 and 2017**

*As of January 2016*

Updated: May 2 2017: 274 NHSN
## NHSN Participating 3rd party vendors (n=16)

<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>Vendor Contact</th>
<th>Contact E-mail/URL</th>
<th>Actively Reporting Antimicrobial Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerner</td>
<td>Kelly Luden</td>
<td><a href="mailto:Kelly.luden@cerner.com">Kelly.luden@cerner.com</a></td>
<td>Yes</td>
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<tr>
<td>Epic Systems Corporation</td>
<td>Jim Russell</td>
<td><a href="mailto:jrussell@epic.com">jrussell@epic.com</a></td>
<td>Yes</td>
</tr>
<tr>
<td>Baxter Healthcare/ICNet</td>
<td>Eric Sato</td>
<td><a href="mailto:Eric_sato@baxter.com">Eric_sato@baxter.com</a></td>
<td>Yes</td>
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<tr>
<td>TheraDoc – Premier</td>
<td>TheraDoc NHSN Team</td>
<td><a href="mailto:NHSN@Premierinc.com">NHSN@Premierinc.com</a></td>
<td>Yes</td>
</tr>
</tbody>
</table>

Relevant to Rhode Island

http://www.sidp.org/aurvendors accessed May 3 2017
Infection Control & Antimicrobial Stewards working together to increase patient safety – prevent HAI’s & *C. difficile*

MUST HAVE Leadership support, protected workload & resources, ability to track and report
Rhode Island HAI Prevention and Antimicrobial Stewardship Coalition – Leadership and Policy Committee

Impact and Opportunities Across the Care Spectrum
Impact and Opportunities Across the Care Spectrum

**Objective:**
Understand barriers and opportunities across the continuum of care.

**Speakers:**
Susan Jameson, PT, CCP, ICCM
Tara Higgins, Pharm. D., CDOE
Janet Robinson, RN, MEd, CIC
Infection Control Protocols

Susan Jameson, PT, CCP, ICCM
Infection control protocols

Sue Jameson
Communication

- Electronic Medical Record Basic Screen
- EC: Thomas (spouse) xxx–xxx–xxxx
- IC: contact precautions “MRSA ankle wound”
- Directions: Depart Woodruff Ave toward RI–108 /.
Clinical Bag on paper barrier in homes
Bag separated: disposable versus reusable equipment is separated
Waterless, regular soap, gloves & sani-cloths
Personal protective equipment is a bag supply
Infection Control

- Communication
- Medication reconciliation at each visit
- Prevent the spread of infection/Monitor for outbreaks
- Report signs & symptoms of infection to MD
- Annual competency
Questions?

Contact Information:
SJameson@southcountyhealth.org
Impact and Opportunities In Outpatient Care Settings

Tara Higgins, Pharm. D., CDOE
Impact and Opportunities In Outpatient Care Settings

Tara Higgins, PharmD, CDOE
Director of Pharmacy
Rhode Island Primary Care Physician Corporation
Outpatient antibiotic use is often inappropriate and/or unnecessary.

- **266.1 million** antibiotic courses were dispensed in US community pharmacies in 2014

- Roughly **1 in 3** outpatient antibiotic prescriptions are considered unnecessary

- Approximately **50%** of outpatient antibiotic prescriptions are inappropriate (e.g., wrong drug, wrong dose, wrong duration)

https://www.cdc.gov/media/releases/2016/p0503-unnecessary-prescriptions.html
## Outpatient Antibiotic Utilization Concerns

<table>
<thead>
<tr>
<th>Outpatient Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>No indication for use - Prescribing of antibiotics for viruses</td>
</tr>
<tr>
<td>Adherence - Patients not completing full course of therapy</td>
</tr>
<tr>
<td>Development of community acquired infections</td>
</tr>
<tr>
<td>Emerging antibiotic resistance</td>
</tr>
<tr>
<td>Patients demanding antibiotics</td>
</tr>
<tr>
<td>Proper disposal of unused antibiotics - Patients sharing antibiotics</td>
</tr>
</tbody>
</table>
Strategies to Address Outpatient Antibiotic Utilization

- Physician Education and Data Reporting
- Patient Education
- Pharmacy Education and Data Reporting

Physician Education and Data Reporting

Patient Education

Pharmacy Education and Data Reporting
Outpatient Care Settings with Opportunities

- Urgent Care/Walk In Treatment Centers
- PCP/Specialists Practices
- Pharmacy Based Clinics
- Dental Practices
The “Wheel” is already created.....
Antibiotic Prescribing Principles

- **MAKE** an accurate diagnosis
- When prescribing an antibiotic, **CHOOSE** the right drug for the right dose and duration.
- **USE** narrow-spectrum antibiotics for simple infections and preserve broad-spectrum drugs for more complex infections.
- **AVOID** prescribing antibiotics for viral infections.
- For empiric treatment, **REVISE** treatment regimen based on patient progress and/or test results.
- **KNOW** the side effects and drug interactions of an antibiotic before prescribing.
- **TEACH** your patients about appropriate antibiotic use and emphasize the importance of taking antibiotics exactly as directed.
Antibiotic Stewardship “It takes a village”

Utilization Reports – what is our benchmark? 50% reduction? Central registry of antibiotic utilization?

Engaging patients/consumers

Empowering “other providers” in the system – pharmacists, nurses, medical assistants

Make resistance data more accessible

Sharing Best Practices – Learn what works
Questions?

Contact Information: THiggins@ripcpc.com
Using NHSN in Long-Term Care Facilities

Janet Robinson, RN, MEd, CIC
Using NHSN in Long-Term Care Facilities

HAI/AMS Coalition - Leadership and Policy Meeting
Janet D. Robinson MEd RN CIC
May 8, 2017
Data Use

Facilities

• Surveillance
• Benchmarking
• Internal Quality Improvement
• Inform conversations with hospitals

CDC

• Establish national rates/benchmarks
• Establish state & regional rates/benchmarks
• Monitor success of prevention efforts
NHSN Modules for LTC

• *C difficile* Infection Reporting
  – New England Nursing Home Quality Care Collaborative

• Multidrug Resistant Organisms Reporting

• Urinary Tract Infection Surveillance

• Prevention Process Measures
  – Hand hygiene
  – Gown and glove use
# RI Data for *C. diff*

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-16</td>
<td>1</td>
</tr>
<tr>
<td>Nov-16</td>
<td>2</td>
</tr>
<tr>
<td>Dec-16</td>
<td>2</td>
</tr>
<tr>
<td>Jan-17</td>
<td>1</td>
</tr>
<tr>
<td>Feb-17</td>
<td>1</td>
</tr>
<tr>
<td>Mar-17</td>
<td>1</td>
</tr>
</tbody>
</table>
Data Interpretation

C. diff Categories

• Incident Event
• Recurrent Event
• Community-onset
• Long-term Care Facility-onset
  • Acute Care Transfer-LTCF-onset
Interested in NHSN?

- [https://www.cdc.gov/nhsn/ltc/](https://www.cdc.gov/nhsn/ltc/)
- Enroll with an established employee
  - Personalized email for easier staff transitions
    - Ex: jrobinson@healthcentricadvisors.org
- Select one module to start (ex: *C diff.*)
- Add additional USER asap
Contact Information:
JRobinson@healthcentricadvisors.org
Please enjoy a short break.
Federal Perspective: HAI Prevention and Antimicrobial Stewardship

Rhode Island HAI Prevention and Antimicrobial Stewardship Coalition – Leadership and Policy Committee

Federal Perspective: HAI Prevention and Antimicrobial Stewardship
Rhode Island HAI Prevention and Antimicrobial Stewardship Coalition – Leadership and Policy Committee

Compliance with State and Federal Guidance
Objective:
Discuss how leaders can use state and federal guidance to achieve success.

Speakers:
Theodore Long, MD, MHS
Kelly Podgorny, DNP, MS, CPHQ, RN
Seth Peters, MPH
Quality Payment Program
Theodore Long, MD, MHS
Quality Payment Program

Rhode Island Healthcare-Acquired Infection Prevention and Antimicrobial Stewardship Coalition Leadership and Policy Committee

Monday, May 8th, 2017
Theodore Long, MD, MHS
Acting Senior Medical Officer
Quality Measurement and Value-Based Incentives Group (QMVIG)
Center for Clinical Standards and Quality (CCSQ)
Disclaimers

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.
CMS Value-based Purchasing Programs

- **Hospital-based Programs**
  - Hospital Inpatient Quality Reporting (IQR) Program
  - Alignment Efforts with the Electronic Health Record (EHR) Incentive Program
  - Hospital Value-Based Purchasing (HVBP) Program
  - Hospital Readmissions Reduction Program (HRRP)
  - Hospital-Acquired Condition Reduction Program (HACRP)

- **Clinician-based Programs**
  - MACRA
Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on volume of services, not value.

The Sustainable Growth Rate (SGR)

- Established in 1997 to control the cost of Medicare payments to physicians

IF

Overall physician costs > Target Medicare expenditures

Physician payments cut across the board

Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians)
The Quality Payment Program

- The Quality Payment Program policy will reform Medicare Part B payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.

- Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

Two tracks to choose from:

- Advanced Alternative Payment Models (APMs)
  If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

- The Merit-based Incentive Payment System (MIPS)
  If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.
Who participates in MIPS?

- Medicare Part B clinicians billing more than $30,000 a year and providing care for more than 100 Medicare patients a year.

- These clinicians include:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists
Pick Your Pace for Participation for the Transitional Year

**Participate in an Advanced Alternative Payment Model**

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

**MIPS**

**Test**
- Submit *some* data after January 1, 2017
- Neutral or small payment adjustment

**Partial Year**
- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

**Full Year**
- Fully participate starting January 1, 2017
- Modest positive payment adjustment

---

*Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.*
What are the Performance Category Weights?

Weights assigned to each category based on a 1 to 100 point scale

**Transition Year Weights**

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
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</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Note:** These are defaults weights; the weights can be adjusted in certain circumstances.
MIPS Performance Category: Quality

- Category Requirements
  - Replaces PQRS and Quality Portion of the Value Modifier
  - “So what?”—Provides for an easier transition due to familiarity

- Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:
  - Outcome measure OR
  - High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

- 60% of final score

- Different requirements for groups reporting CMS Web Interface or those in MIPS APMs

- May also select specialty-specific set of measures
MIPS Performance Category: Quality Measures for Antimicrobial Stewardship and Appropriate Treatment of Infectious Disease

- **Antimicrobial Stewardship**
  - Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use
  - Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse)
  - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

- **Appropriate Treatment**
  - Acute Otitis Externa (AOE): Topical Therapy
  - Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)
  - Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia
  - HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
  - HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis
MIPS Performance Category: Cost

- No reporting requirement; 0% of final score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.

*Keep in mind:*

- Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)
- Only the scoring is different
MIPS Performance Category: Improvement Activities

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access

- **Clinicians choose** from 90+ activities under 9 subcategories:

|-----------------------------|--------------------------|---------------------|
MIPS Performance Category: Improvement Activities

- Communicate specialist reports back to referring clinicians to close referral loop
- Implement practice improvements for bilateral exchange of patient information
- Participate in regular training in care coordination
- Collect and use patient experience and satisfaction data to improve care
- Engage new and existing Medicaid patients
- Implement practice improvements that engage community resources to support patient health goals
- Implement improvements that contribute to more timely communication of test results
- Participate in a Qualified Clinical Data Registry (QCDR)
- Implement care coordination agreements that promote improvements in patient tracking across settings
MIPS Performance Category: Advancing Care Information

- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
- Greater flexibility in choosing measures
- In 2017, there are **2 measure sets for reporting based on EHR edition**:
  - Advancing Care Information Objectives and Measures
  - 2017 Advancing Care Information Transition Objectives and Measures
Advanced Alternative Payment Models

- Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients’ outcomes.

- It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

---

**Advanced APMs**

- Advanced APM-specific rewards
  - + 5% lump sum incentive
Where can I go to learn more?
Quality Payment Program

Transforming Clinical Practice Initiative (TCPI): TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click here to find help in your area.

Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs): The QIO Program’s 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found here.

If you’re in an APM: The Innovation Center’s Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you’re in an APM that is not an Advanced APM, then the Learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model’s support inbox.
Contact Information:

Theodore Long, MD, MHS
Senior Medical Officer
Quality Measurement and Value-Based Incentives Group (QMVIG)
Center for Clinical Standards and Quality (CCSQ)

Email: Theodore.Long@cms.hhs.gov
The Joint Commission’s Infection Prevention Standards and National Patient Safety Goals

Kelly Podgorny, DNP, MS, CPHQ, RN
The RI HAI Prevention and Antimicrobial Stewardship Coalition – Leadership and Policy Committee Meeting

May 8, 2017
Objectives

To provide information on:

- The Joint Commission and its focus on High Reliability.
- National infection issues.
- The importance of infection prevention in all healthcare settings and leadership’s role.
- The Joint Commission’s infection and prevention (IC) standards. Also, the infection-focused National Patient Safety Goals (NPSGs).
- The new antimicrobial stewardship standard.
The Joint Commission

- Independent, non-governmental, not-for-profit
- Oldest and largest standards-setting and accrediting body in health care
- Accredits/certifies over 21,000 healthcare organizations and programs
The Joint Commission

Mission: To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

Vision Statement: All people always experience the safest, highest quality, best-value health care across all settings.
High Reliability

“The road to high reliability is an ongoing journey. It’s a commitment to patient safety and the way we deliver quality health care.”

Mark Chassin, MD, FACP, MPP, MPH, President and Chief Executive Officer of The Joint Commission
HIGH RELIABILITY MODEL

Leadership
Commitment to zero patient harm

Safety Culture
Empowering staff to speak up

Robust Process Improvement®
Systematic, data-driven approach to complex problem solving

## Key to Terms

<table>
<thead>
<tr>
<th>#</th>
<th>Acronym</th>
<th>Joint Commission Terms</th>
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<tbody>
<tr>
<td>1</td>
<td>EP</td>
<td>Element of Performance</td>
</tr>
<tr>
<td>2</td>
<td>IC</td>
<td>Infection Prevention and Control Standards</td>
</tr>
<tr>
<td>3</td>
<td>LD</td>
<td>Leadership Standards</td>
</tr>
<tr>
<td>4</td>
<td>MM</td>
<td>Medication Management Standards</td>
</tr>
<tr>
<td>5</td>
<td>NPSG</td>
<td>National Patient Safety Goal</td>
</tr>
</tbody>
</table>
National Infection Issues

- Infectious Diseases
  - Ebola
  - Zika
  - Influenza

- Disinfection and Sterilization
  - Endoscopes

- Sepsis

- Healthcare-Associated Infections
  - MDROs
  - CLABSI
  - SSI
  - CAUTI

- Antimicrobial Resistance
  - Antimicrobial Stewardship Program
The Joint Commission’s Standards focusing on Infection Prevention and Control
Leadership (LD) Standard

Standard: LD.01.03.01: The governing body is ultimately accountable for the safety and quality of care, treatment and services.

- **EP 5.** The governing body provides the resources needed to maintain safety, quality care, treatment and services.
Infection Prevention and Control Standards: Chapter Outline

I. Planning
   A. Responsibility (IC.01.01.01)
   B. Resources (IC.01.02.01)
   C. Risks (IC.01.03.01)
   D. Goals (IC.01.04.01)
   E. Activities (IC.01.05.01)
   F. Influx (IC.01.06.01)

II. Implementation
   A. Activities (IC.02.01.01)
   B. Medical Equipment, Devices, and Supplies (IC.02.02.01)
   C. Transmission of Infections (IC.02.03.01)
   D. Influenza Vaccinations (IC.02.04.01)

III. Evaluation and Improvement (IC.03.01.01)
Standard IC.01.06.01: The hospital prepares to respond to an influx of potentially infectious patients.

EP 2 The hospital obtains current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients.

EP 3 The hospital has a method for communicating critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients.

EP 4 The hospital describes, in writing, how it will respond to an influx of potentially infectious patients.
Standard IC.02.02.01 The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

**EP 1** The hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment, devices, and supplies.

**EP 2** The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.

(See next slide for remaining EPs)
Infection Prevention and Control Standards

**EP 3** The hospital implements infection prevention and control activities when doing the following: Disposing of medical equipment, devices, and supplies.

**EP 4** The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

**EP 5** When reprocessing single-use devices, the hospital implements infection prevention and control activities that are consistent with regulatory and professional standards.
IC.02.04.01: The hospital offers vaccination against influenza to licensed independent practitioners and staff.

- Nine EPs for this standard.
- Will focus on 6 of the EPs including that the organization:
  - Establishes an influenza vaccination program for licensed independent practitioners and staff.
  - Provides education for licensed independent practitioners and staff.
  - Sets incremental goals, consistent with achieving the 90% rate for 2020.
  - Evaluates the reasons the influenza vaccination is declined.
  - Improves vaccination rates according to established goals.
  - Provides influenza vaccination rate data to key stakeholders.
Infection Prevention and Control-focused
National Patient Safety Goals (NPSGs)
When does a healthcare issue meet the requirements for a NPSG?

An issue will be considered for a NPSG when:

- There is evidence that the issue has resulted in serious patient harm.
- There is benefit in bringing the issue to the attention of the health care field through the spotlight of an NPSG.
- The issue is widespread and affects many patients.
- Patient harm can be prevented.
- A high reliability organization can detect the problem.
Healthcare-Associated Infections (HAIs)

Every day, patients get infections in healthcare facilities while they are being treated for something else. These infections can have devastating emotional, financial, and medical effects. Worst of all, they can be deadly. [https://www.cdc.gov/hai/patientsafety/patient-safety.html](https://www.cdc.gov/hai/patientsafety/patient-safety.html)
The following HAI issues have met these criteria and are NPSGs:

- **Handwashing** (NPSG.07.01.01)
- **Preventing Multidrug-Resistant Organisms** (NPSG.07.03.01)
- **Preventing Central Line-Associated Blood Stream Infections** (NPSG.07.04.01)
- **Preventing Surgical Site Infections** (NPSG.07.05.01)
- **Preventing Catheter-Associated Urinary Tract Infections** (NPSG.07.06.01)
Antimicrobial Stewardship (AMS)

Antimicrobial Stewardship (MM.09.01.01) standard became effective January 1, 2017.

- The organization has an **AMS program** based on scientific literature.
- Settings include critical access hospitals, hospitals and nursing care centers.
- There are 8 EPs. Will focus on 6 of these EPs:
  - Leadership establishes AMS as an organization priority.
  - There is a multidisciplinary AMS committee.
  - Includes seven core elements established by the CDC.
  - Uses organization approved multidisciplinary protocols.
  - Collects, analyzes and reports data on its AMS program.
  - Action is taken when improvements are identified.
These slides are current as of 05/08/2017. The Joint Commission reserves the right to change the content of the information, as appropriate.

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Questions

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Carbapenem Resistant Enterobacteriaceae (CRE) in Rhode Island

Seth Peters, MPH
Carbapenem Resistant Enterobacteriaceae (CRE) in Rhode Island

Seth Peters, MPH
Public Health Epidemiologist

May 8, 2017
Rhode Island HAI Prevention and Antimicrobial Stewardship Coalition:
Leadership and Policy Committee Meeting
Introduction:

• Background

• Centers for Disease Control and Prevention (CDC) recommendations

• Council of State and Territorial Epidemiologists (CSTE) position statement

• Rhode Island Department of Health (RIDOH) activities
**Background**:  
- Carbapenems are last line antibiotics  
- CRE difficult and costly to treat  
- High mortality rates  
- MRSA vs. CRE  
- Carbapenemase producing CRE (CP-CRE)
CRE Background

Risk and Prevention:

• CRE is primarily isolated from people with healthcare exposures.

• Most transmission occurring in healthcare settings.

• Identify people colonized or infected with CRE while in healthcare settings.

• Implement interventions to prevent transmission.
CDC Recommendations

State Health Departments should⁴:

• Set up surveillance
• Understand prevalence & incidence
• Be proactive in preventing CRE
• Increase healthcare facility awareness
• Add CRE infections to Notifiable Diseases List
**Revised Position Statement April 2017:**

Recommendations include:

- CDC add CRE and CP-CRE to the nationally notifiable conditions list.
  - CP-CRE should be immediately notifiable if a novel carbapenemase (CP) is suspected.
  - CRE routinely notifiable, unless a novel CP is suspected.
1.4.3 Reportable Diseases and Conditions

E. Other reportable conditions (within 4 days)

5. Carbapenem resistant organisms

a. Laboratories must submit specimen or isolate to Rhode Island State Health Lab (RISHL)
RIDOH Planning

RIDOH CRE Surveillance:

- National Electronic Disease Surveillance System (NEDSS)
- Electronic Laboratory Reporting (ELR)
- CRE Registry – provider accessible
Voluntary Report of CRE in Rhode Island

CARBAPENEM-RESISTANT ENTEROBACTERIACEAE, RHODE ISLAND 2009 - 2016 (N=105)


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Engaging Partners to Support Facility and Health System Initiatives

Rhode Island HAI Prevention and Antimicrobial Stewardship Coalition – Leadership and Policy Committee
Objective:
Discuss how healthcare leaders can collaborate with patients and families to overcome HAI and AMS challenges.

Speaker:
Russel Cooney
Engaging the Patient Voice

Russel Cooney
Engaging the Patient Voice

New England QIN-QIO Regional Approach
When people become patients...

Our work to improve healthcare is not complete without the voices of patients and their family members.
New England QIN-QIO
Patient and Family Advisory Council (PFAC)

Regional PFAC Members

Leadership (Admin & Clinical)

State Liaison
Gateways to Engagement

Setting the Table in the Organization

Recruiting Patient & Family Advisors

Preparing & Orienting PFAC Members

First Meeting

Sustainable Practices
We envision a system where patients, families and caregivers, as the most important members of the healthcare team, are partnered in positive, productive collaboration in all aspects of healthcare design and delivery.
Setting The Table: Developing our Charter

Includes...

• Vision
• Scope
• Patient Engagement Facilitator
• Governance
• Membership Definition
• Structure
• Time Commitment
• Flexibility
Recruiting Patient & Families

- Referrals
- Application
- Interviews
Preparing & Orienting New Members

Quality Improvement Network
Organization
PFAC (charter)
Prepare
Share
Reinforce
First Meeting: 
Prepping For Success

• **Who**
  - Leadership Team
  - PFAC Team *(State Liaisons)*
  - Members

• **Agenda**
  - Clear goals
  - Vision Statement
  - Story Telling

• **Logistics**
  - Access
  - Meeting date, time, location (webinar)
  - Ground rules
  - Checking in
  - Capturing Feedback
Harnessing Personal Experience: The Journey of a Story

Moving to Representative Voice

Healthcare Encounters - Connection to Disease or Organizational Constructs - Combining the experience of encounters with what you now know about being a user of the healthcare system

- Personal Experience
- Identifying as Part of a Larger Group
- Using Experience and Knowledge of the Group to Represent Needs
Lessons Learned Along the Way: Where We Are Today ...
Lessons Learned Along the Way: Key Takeaways ...

Leadership and staff buy-in is critical

PFAC member buy-in and a complete understanding of our world and what they can bring to it

Integrating PFAC (Patient Voice) – start small

- Share stories at learning events
- Review materials
- Develop materials
- Design our approach

Closing the feedback loop so members can see the value their participation brings to the table

Identifying strategies and tactics to engage staff and patients to develop, optimize and sustain the PFAC
We’ve been busy!!
Informing and Driving Quality
Are You Feeling Crushed by Regulations Impacting Payments?

- MACRA
- HEDIS
- MIPS
- PQRS
- PRESS GANEY
- CMS
- CDC
- NCQA
- HCAHPS
- JCAHO
Why Should You Consider a PFAC:

Building patient and family engagement into your current office policies and practices can help:

• Improve Quality and Safety
• Improve financial performance
• Improve patient outcomes
• Enhance market share and competitiveness
• Increase employee satisfaction and retention
What Questions Do You Have?
Contact Information

Russ Cooney
rcooney@healthcentricadvisors.org
Closing Remarks

Nicole Alexander-Scott, MD, MPH
Director, Rhode Island Department of Health
Today’s objectives were to:

Where We Are Today
- Why are we here and how did we get here?
- How does the Coalition support state-wide collaboration

Understanding Financial Impact and Preventing Litigation
- Financial impact and underlying resource needs
- Preventing litigation and promoting patient safety

Reporting and Quality Metrics Across the Continuum of Care
- Public information and quality metrics
- Impact and opportunities across the care continuum

Achieving Financial Security through Compliance and Partner Engagement
- Compliance with state and federal guidance
- Engaging partners to support facility and health system initiatives
Key Message:
Listen to your experts
(It is why you hired them*)

*If you have not hired experts, consider that your first step.
Closing and Next Steps

TWO TRACKS FOCUSED ON A SINGLE GOAL: Protecting the health of Rhode Islanders and the sustainability of our healthcare system.

RI HAI Prevention and Antimicrobial Stewardship Coalition

Leadership and Policy Committee

- Work with executive and state leadership to ensure facility policies and resource allocation adequately support HAI prevention and antimicrobial stewardship.
- Develop and support state and national policies that align with coalition goals.

Education and Best Practice Workgroup

- Work with HAI prevention/antimicrobial stewardship leads, champions and subject matter experts to identify gaps in state or facility programs and develop best practices.
- Provide expert information to Leadership and Policy Committee.

- Meetings will be held for each track every 6 months to advance Coalition aims.
- Existing meetings and groups will be leveraged to reduce duplication and support coordination.
Nicole Alexander-Scott, MD, MPH
Director
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Thank you to all of our partners here today

Heritage Hills Nursing & Rehabilitation Center
Memorial Hospital Of Rhode Island
Hallworth House Nursing And Rehabilitation Center
Care Transformation Collaborative
Centers For Medicare And Medicaid Services
Elderwood Of Scallop Shell At Wakefield
Tockwotton On The WaterfrontNational Bureau Of Economic Research
University Of Rhode Island School Of Pharmacy
Yale University Institution For Social And Policy Studies
West View Nursing And Rehabilitation Center
Landmark Medical Center
ID Management Partners Rehabilitation Hospital Of Rhode Island
Mansion Nursing And Rehab Center Rhode Island Department Of Health Alpine Nursing Home
Healthcentric Advisors Pawtucket Skilled Nursing And Rehab Chartercare
Lifespan Steere House Optumcare South County Health Hattle Ide Chaffee Home
Care Resource Overlook Nursing & Rehab Center The Claffin Company
Briarcliffe Manor Rhode Island Hospital/hasbro Children's Evergreen House
University Of Rhode Island Saint Elizabeth Manor VNA Of Rhode Island A Place For Mom
Grace Barker Nursing Center Senior Helpers Of Rhode Island Woodpecker Hill Health Center
Summit Commons Roger Williams Medical Center The Miriam Hospital
Genesis HealthCare Rhode Island State Health Laboratories Coastal Medical, Inc
West Shore Health Center Roberts Health CentreWesterly Health Center
The Holiday Retirement Home Riverview Healthcare CommunityEast Side Lab
Linn Health Care Center Rhode Island PRimary Care Physicians Company Berkshire Place
Oakhill Health & Rehabilitation Roger Williams Medical Center The Joint Commission
Hope Nursing Home Care Silver Creek Manor Scandinavian Home Women & Infants Hospital
Cherry Hill Manor Royal Middletown Nursing & Rehab Center Grand Islander
Wingate On Blackstone Blvd Rhode Island Hospital South County Home Health
Integra Westerly Hospital Our Lady Of Fatima Cortland Place
Genesis Warren Center Office Of Senator Sheldon Whitehouse Newport Hospital
Bayberry Commons Providence Community Health Centers Hospital Association Of Rhode Island
Jeanne Jugan Residence Rhode Island College School Of Nursing Kent County Memorial Hospital
Bethany Home Of RI Providence VA Medical Center Harris Health Center
Brown University Warren Alpert School Of Medicine Hopkins Manor, Ltd
Mount St. Rita Health Centre VA Medical Center Providence, RI
Health Policy Analytics, LLC South Kingstown Nursing & Rehab
Oakland Grove Health Care Center
Elmwood Nursing And Rehabilitation Center
Blue Cross Blue Shield Of Rhode Island
Care New England Health System
Medical Associated Of Rhode Island
Neighborhood Health Plan Of Rhode Island